FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MOP - 175152

PRELIMINARY RECITALS

Pursuant to a petition filed on June 25, 2016, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Public Assistance Collection Unit regarding Medical Assistance (MA), a hearing was held on October 27, 2016, at Waukesha, Wisconsin. The record was held open post-hearing for the submission of briefs by both parties. The record was closed on December 17, 2016

The issue for determination is whether the agency correctly seeks to recover an overissuance of MA benefits as follows:

May 1, 2008 – April 30, 2009	$151,207.53	(Institutional MA)
March 4, 2009 – February 28, 2010	$243,856.33	(Community Waivers)
March 1, 2010 – February 28, 2011	$240,178.75	(Community Waivers)
March 1, 2011 – February 29, 2012	$261,666.91	(Community Waivers)
March 1, 2012 – September 30, 2012	$151,283.28	(Community Waivers)
February 1, 2013 – January 31, 2014	$259,828.76	(MAPP)
February 1, 2014 – April 30, 2014	$ 64,308.77	(MAPP)
May 1, 2009 – June 30, 2009	$ 1,267.30	(QMB)
February 1, 2010 – December 31, 2010	$ 1,215.50	(QMB)
January 1, 2011 – December 31, 2011	$ 1,384.80	(QMB)
May 1, 2012 – December 31, 2012	$ 1,198.00	(QMB)
March 1, 2013 – December 31, 2013	$ 1,258.80	(QMB)
January 1, 2014 – April 30, 2014	$ 944.10	(QMB)

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: [redacted]
Public Assistance Collection Unit
P.O. Box 8938
Madison, WI 53708-8938

ADMINISTRATIVE LAW JUDGE:
Debra Bursinger
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Waukesha County.

2. In or about December, 1990, a structured settlement agreement was executed that established an annuity for the Petitioner. The settlement was related to an accident that left the Petitioner disabled. The annuity is owned by [redacted] and [redacted]. The annuity provides for monthly payments of $4,000 to the Petitioner beginning November 1, 1992 with payments to increase annually by 3% beginning November 1, 1993. The payments are to continue while the Petitioner is living. (See Exhibit R-7)

3. From November, 2007 – October, 2014, the Petitioner's monthly payments from this annuity were deposited electronically into Petitioner's Acct # [redacted] at [redacted], as follows:

November 1, 2007 – October 1, 2008	$6,231.87/month
November 1, 2008 - October 1, 2009	$6,418.83/month
November 1, 2009 – October 1, 2010	$6,611.39/month
November 1, 2010 – October 1, 2011	$6,809.73/month
November 1, 2011 – October 1, 2012	$7,014.02/month
November 1, 2012 – October 1, 2013	$7,224.44/month
November 1, 2013 – October 1, 2014	$7,441.17/month

(See Exhibit R-7)

4. On February 7, 2008, the Petitioner submitted a Wisconsin MA EBD Application to the agency requesting Institutional MA. Petitioner reported gross income from SSDI of $442/month. He reported out-of-pocket medical expenses of $700/month for [redacted] insurance. He reported assets that included a checking/savings account at [redacted] Acct # [redacted]. The Petitioner submitted bank statements for Acct # [redacted] dated October 31, 2007, November 30, 2007 and December 31, 2007. Those statements show transfers from another bank account (# [redacted]). (See Exhibit R-11). Acct# [redacted] is the account into which the annuity payments were deposited.

5. On December 18, 2008, the Petitioner submitted a renewal application and again reported his only income was from Social Security and his only bank account was the Enterprise Acct # [redacted]. (See Exhibit R-3).

4. On March 17, 2008, April 14, 2008, May 12, 2008 and December 8, 2008, the agency issued Notices of Decision to the Petitioner informing him that he was enrolled in Institutional MA effective February 1, 2008. The notices informed him of his monthly cost share. The notices also informed him that the determination of his eligibility and cost share was based on his reported gross monthly income from Social Security. In addition, the notices advised the Petitioner of the requirement to report to the agency within 10 days if he had a change in income, medical expenses or assets. (See Exhibit R-5).

5. On January 8, 2009, the Petitioner submitted an Application for a Community Waiver Program to the agency. He reported income of $480.20/month from SSDI and $238/month from SSDC. He reported rent of $749/month. (See Exhibit R-3). Petitioner submitted subsequent renewal applications for community waivers and Medicare Premium Assistance ("QMB") on April 8, 2009; February 19, 2010; February 20, 2011; March 15, 2012; and December 11, 2012. In each renewal, Petitioner reported his only income was from Social Security and his only bank account was [redacted] Acct # [redacted]. (See Exhibit R-3).

6. The agency issued Notices of Decision to the Petitioner following each renewal application informing him of continuing eligibility for community waivers with no monthly premium and for QMB with no monthly premium. Notices were issued on April 2, 2009, May 28, 2009, November 2, 2009, March 1, 2010, October 25, 2010, March 7, 2011, October 24, 2011, April 4, 2012 and August 27, 2012. The notices informed him that these determinations were based on gross monthly income from Social Security. The notices advised the Petitioner of the requirement to report to the agency within 10 days if he had a change in income, medical expenses or assets. (See Exhibit R-5).

7. On January 7, 2013, the Petitioner submitted November, 2012 bank statements for Acct # [redacted]. On January 9, 2013, the agency requested additional information regarding Petitioner's checking account. A worker had noticed that the Petitioner's checking account showed deposits from another account into the Petitioner's account. Petitioner reported it was his dad's account. Verification was requested and the case was pended. (See Exhibit R-6). On January 29, 2013, the Petitioner provided bank statements for Acct # [redacted] and his father's Acct # [redacted]. (See Exhibit R-11).

8. Petitioner submitted renewal applications on January 10, 2013; March 19, 2013, March 19, 2014 and April 9, 2014. He reported his only income was from Social Security, no assets, rent and utility expenses. He reported the checking account at [redacted] Acct # [redacted]. He reported starting an in-kind job on October 1, 2012 with income of $30/month. (See Exhibit R-3).

9. The agency issued Notices of Decision to the Petitioner following each renewal application informing him of continuing eligibility for community waivers with no monthly premium, for QMB with no monthly cost share and for Medicaid Purchase Plan (MAPP) effective February 1, 2013 with no monthly cost share. Notices were issued on January 10, 2013, April, 2013 and April 8, 2014. The notices informed him that these determinations were based on gross monthly income from Social Security. The notices further advised the Petitioner of the requirement to report to the agency within 10 days if he had a change in income, medical expenses or assets. (See Exhibit R-5).

10. On April 29, 2014, the agency issued a Notice of Decision to the Petitioner advising him that he was not enrolled in BC+ effective May 1, 2014 due to income exceeding the program limit, and that his community waivers, MAPP and QMB benefits would end effective May 1, 2014 due to not providing required verifications. (See Exhibit R-5).

11. On August 26, 2014 an Order on Petitioner for Transfer of Property to Trust under Sec. 49.454, Wis. Stats. was signed by the Waukesha County Circuit Court in Case No. [redacted]. This order required that all payments from the Petitioner's structured settlement annuity contract are irrevocably assigned to a [redacted] trust for the sole benefit of the Petitioner. (See Exhibit R-7).

12. On May 17, 2016, the agency issued Wisconsin Medicaid and BC+ Overpayment Notices and worksheets to the Petitioner informing him that the agency intends to recover MA overissuances for client error in failing to report household income. The overpayment notices were for the following periods and amounts:

May 1, 2008 – April 30, 2009	$151,207.53	(Institutional MA)
March 4, 2009 – February 28, 2010	$243,856.33	(Community Waivers) **
March 1, 2010 – February 28, 2011	$240,178.75	(Community Waivers)
March 1, 2011 – February 29, 2012	$261,666.91	(Community Waivers)
March 1, 2012 – September 30, 2012	$151,283.28	(Community Waivers)
February 1, 2013 – January 31, 2014	$259,828.76	(MAPP) **
February 1, 2014 – April 30, 2014	$ 64,308.77	(MAPP) **
May 1, 2009 – June 30, 2009	$ 1,267.30	(QMB)
February 1, 2010 – Dec. 31, 2010	$ 1,215.50	(QMB)
January 1, 2011 – Dec. 31, 2011	$ 1,384.80	(QMB)
May 1, 2012 – December 31, 2012	$ 1,198.00	(QMB)
March 1, 2013 – December 31, 2013	$ 1,258.80	(QMB)
January 1, 2014 – April 30, 2014	$ 944.10	(QMB)

** These claims were subsequently revised. See Finding of Fact #14 below.

13. On June 25, 2016, an appeal was filed on behalf of the Petitioner with the Division of Hearings and Appeals.

14. On August 1, 2016, the agency issued notices that revised the overpayment claims. The bases for the overpayments were stated as member error in misstating or omitting facts, failing to report changes within 10 days and "fraud" defined as "intentionally omitting or providing erroneous information at the time of application or review." The claims were revised as follows:

May 1, 2009 – February 28, 2010	$236,406.78	(Community Waivers)
February 1, 2013 – April 30, 2014	$323,921.77	(MAPP)

DISCUSSION

MA overpayment recovery is authorized by Wis. Stat., §49.497(1):

> (a) The department may recover any payment made incorrectly for benefits provided under this subchapter or s. 49.665 if the incorrect payment results from any of the following:
>
> 1. A misstatement or omission of fact by a person supplying information in an application for benefits under this subchapter or s. 49.665.

> 2. The failure of a Medical Assistance or Badger Care recipient or any other person responsible for giving information on the recipient's behalf to report the receipt of income or assets in an amount that would have affected the recipient's eligibility for benefits.
>
> 3. The failure of a Medical Assistance or Badger Care recipient or any other person responsible for giving information on the recipient's behalf to report any change in the recipient's financial or nonfinancial situation or eligibility characteristics that would have affected the recipient's eligibility for benefits or the recipient's cost-sharing requirements.

See also the Medicaid Eligibility Handbook, § 22.2. The overpayment must be caused by the client's error. Overpayments caused by agency error are not recoverable. Id.

Financial eligibility for MA programs is determined by an applicant's gross countable income which includes all earned and unearned income that is not exempt or disregarded. MEH, § 15.2.1. In addition, an individual's assets must not exceed the asset limit. MEH, § 16.1.

The overpayment notices state that the agency seeks to recover an overissuance of MA benefits (Institutional MA, Community Waivers, MAPP and QMB) from the Petitioner for the period of May 1, 2008 – April 30, 2014 due to a client error in misstating or omitting information, failing to report changes in a timely manner and "fraud". As a result, the agency contends the Petitioner received benefits that he was not entitled to receive. At the hearing, the agency made further assertions that the overpayments were the result of the Petitioner being over the asset limit and divesting resources by transferring his annuity income to his father's bank account.

I note that the Petitioner does not dispute that he did not report the annuity income to the agency at the time of initial application and/or at the time of renewals for MA programs from February, 2008 – April, 2014. The Petitioner further does not dispute that the annuity income is countable income according to the MEH for purposes of determining eligibility.

The Petitioner makes the following arguments with regard to the overpayment claims:

> 1. The overpayments for May, 2008 – December, 2008 and January, 2013 – April, 2014 are agency error and therefore are not recoverable.
> 2. There is insufficient evidence to support an overpayment for the period of January, 2010 – February, 2011.
> 3. The overpayment amount is incorrect because the agency failed to determine Petitioner's deductible based on his actual income and/or failed to determine his cost share based on actual income.
> 4. There is insufficient evidence to show the Petitioner's assets exceeded MA income limits and/or divested resources.

A. Bases for the Overpayment

The agency's initial overpayment notices state that its action in seeking to recover an overpayment is based on client error in failing to report household income. Revised notices for two of the overpayment periods state that the overpayments are the result of client error in misstating or omitting facts, failing to report changes in a timely manner and fraud. At the hearing, the agency further asserted that the overpayments are based on Petitioner being over the asset limit and divesting resources.

The Seventh Circuit Court of Appeals has held that the demands of procedural due process require that recipients of public assistance be given adequate notice of adverse action. *Dilda v. Quern*, 612 F.2d 1055 (7th Cir. 1980). That court found that a state agency had violated the due process rights of public assistance recipients because the notice advising them of the reduction or cancellation of their benefits failed to provide the recipient with a detailed notice showing the breakdown of income and allowable deductions. Id. This holding is reflected in Wisconsin policy:

> "Each client has the right to adequate and timely notice of adverse action." Income Maintenance Manual (IMM) §§ 3.2.1 and 3.2.2.
>
> "Notify the member or the member's representative of the period of ineligibility, the reason for his or her ineligibility, and the amounts incorrectly paid and request arrangement of repayment within a specified period of time." Medicaid Eligibility Handbook (MEH), § 22.2.3.2.

Subsequent to Dilda, the Wisconsin Court of Appeals further addressed the issue of procedural due process and the adequacy of administrative notice of an action in *Homeward Bound Services, Inc. v. Office of the Commissioner of Insurance*, 2006 WI App 208.296 Wis. 2d 481.

> "The procedural guarantees of the due process clause require that a party proceeded against by an administrative agency have notice before the hearing of the alleged violations that will be at issue at the hearing. If a party asserts that notice is insufficient, it must demonstrate prejudice caused by the insufficient notice. Whether notice is sufficient to provide due process presents a question of law, and our review is therefore de novo." (citations omitted).
> Id. at ¶ 39.

The issue of the adequacy of procedural due process notice was also addressed in *Kocher v. DHSS*, 152 Wis. 2d 170 (1989). In that case, the agency issued a notice to the Petitioner advising the Petitioner of the agency's determination that his MA benefits would be terminated. The Petitioner argued that the notice did not meet all of the specific requirements required for termination of public benefits. The court found that the Petitioner was not prejudiced by the inadequate notice because the notice was supplemented by a "case summary" prior to the hearing which "clearly elaborated the nature and reasons for the termination" and referred to various MA Eligibility Handbook provisions which described the ramifications of the action. Id.

In this case, the agency asserted that, in addition to the bases for the overpayments as stated in the overpayment notices, the overpayments occurred as the result of divestment and exceeding the asset limit for MA programs. The hearing was the first time that these were asserted as bases for the overpayments.

The Petitioner argues that the agency is precluded by procedural due process from asserting these additional bases for the overpayments because of lack of prior notice. The Petitioner argues that he is prejudiced by the insufficient notice of the divestment issue because the details of when and how much was divested is not clear and he would have been able to present a defense to show money was properly transferred between accounts or to his father to pay for allowable expenses if he had been aware that the issue would be raised. Similarly, with regard to exceeding the asset limit, the Petitioner argues that it is not clear when he may have exceeded the asset limit and without prior notice, he was not given an opportunity to present a proper defense to that issue.

I agree with the Petitioner that, in an overpayment this size involving a number of different programs with different policies concerning asset limits, the lack of prior notice of additional bases for the overpayment

was prejudicial to the Petitioner. In a complex case such as this, it is not possible for the Petitioner to present information with regard to divestment or exceeding asset limits without prior knowledge of exactly what the agency contends was a divestment or when the Petitioner exceeded asset limits. This case is distinguishable from *Kocher* where a summary was provided prior to the hearing that gave the Petitioner notice of the details and citations to MA Eligibility Handbook provisions regarding the ramifications of the action. In this case, there is evidence that any documents prior to the hearing would have rehabilitated the overpayment notices to give the Petitioner notice that the agency would assert a divestment or failure to report assets over the asset limit as bases for the overpayments.

The revised overpayment notices covering a portion of the total overpayment indicate that the overpayments are based on Petitioner omitting facts or failing to report changes. While the notices are not specific with regard to what facts were omitted or what changes were not reported, taken together with the original notices, one would reasonably conclude from the totality of the original notices and the revised notices that the Petitioner's annuity income was the item omitted by the Petitioner or the change that he failed to report. The revised notices also were not sufficient to advise the Petitioner that the overpayments were based on being over the asset limit or divesting resources.

With regard to the "fraud" basis asserted in the revised notices, there is no authority in Wis. Stats., §49.497 to recover an MA overpayment based on fraud as stated for the two revised claims in the notices of August 1, 2016. In addition to including this reason for the overpayment in the two notices, the agency also asserted in its written closing that the Petitioner "purposefully withheld information" and "intentionally failed to disclose his bank account" for purposes of "deceiving" the agency. There is no authority to recover under §49.497 on the basis of fraud and there is no intent element in the overpayment determination. Therefore, I make no such finding of intent or fraud in this decision.

Because the agency notices establish exceeding the income limit as the only basis for the overpayment, the agency cannot present arguments at the hearing about additional bases for the action without violating procedural due process. Therefore, this decision will address the issue of an overpayment based solely on the agency claim that Petitioner's income exceeded the income limit.

B. Overpayment for the period of May, 2008 – December, 2008 and January, 2013 – April, 2014

The Petitioner asserts that the overissuance of MA benefits for the periods of May 1, 2008 – December 31, 2008 and January, 2013 – April, 2014 was the result of agency error and DHS cannot recover an overpayment that results from agency error. The Petitioner bases his argument on the assertion that the bank statements submitted with his application on February 7, 2008 showed that he had income in addition to the Social Security income as reflected by substantial transfers into and out of Acct # [redacted] from Acct # [redacted]. He argues that the very purpose of submitting verification of financial information is to enable the agency to determine if the individual is eligible. He asserts that he submitted the requested financial verifications and the agency failed to conduct a proper analysis of his eligibility based on that verification.

At the hearing, the DHS representative conceded that its determination of eligibility was based on the October, November and December, 2008 bank statements submitted by the Petitioner with his application. These bank statements are for Acct # [redacted]. The statements show deposits each month from Acct # [redacted].

The agency argues that the Petitioner does not dispute that he did not report his annuity income and that this income clearly put him over the income limit for the MA programs. As for the Petitioner's rebuttal that this was an agency error, the agency argues that it acts in response to complete and truthful information. It further argues that accepting the Petitioner's argument that the agency should have noted the deposits from another bank account in the bank statements he submitted would place an untenable burden on the agency to "ferret out unreported and hidden information that applicants are already required to provide."

I concur with the agency that the overpayment resulted from client error in failing to report income, not from agency error. The Petitioner had the obligation to accurately report his income when he applied. He concedes that he did not report the annuity income. While the Petitioner did submit bank statements that showed additional income, the Petitioner's argument would indeed shift the burden from applicants being required to accurately report income on their application to requiring the agency to "discover" income or assets in financial statements that were not reported on the application. This was not the intent of the regulations.

C. Overpayment for January, 2010 – February, 2011

The Petitioner argues that there is insufficient evidence to support the overpayment for the period of January, 2010 – February, 2011. The Petitioner notes that MA eligibility must be reviewed every 12 months. The agency submitted renewals for the Petitioner dated December 18, 2008 and February 20, 2011. The Petitioner noted that there should have been a renewal completed in December, 2009 but the agency did not submit this renewal as evidence.

The issue is whether the Petitioner received an overissuance of benefits based on a failure to report his annuity income. The agency did present evidence of the benefits issued to the Petitioner for the period of January, 2010 – February, 2011. There was evidence that the Petitioner did not report his annuity income to the agency until 2014, including the Petitioner's own testimony that he did not report his annuity income until 2014. Therefore, I find that there is sufficient evidence to conclude there was an overpayment for the period of January, 2010 – February, 2011.

D. Amount of the Overpayment

The Petitioner argues that federal regulation requires the agency to consider all bases of eligibility for an EBD applicant. 42 CFR § 435.916(f)(1). He notes that this is known as the "MA cascade" and it is a function that is built into the CARES system. Section 24.2 of the MEH states:

> "When a Medicaid applicant is ineligible for Medicaid solely because he or she has income that exceeds the Medicaid medically needy income limit, he or she can become eligible by meeting the Medicaid deductible. 'Meeting the Medicaid deductible' means incurring medical costs that equal the dollar amount of the deductible."

MEH, § 24.2.

The Petitioner asserts that although he does not dispute the fact that his monthly income exceeded program limits, he was not necessarily ineligible for all of the MA benefits he received. He may have been eligible for MA card services with a deductible and/or a waiver program with a spend-down or cost share. The Petitioner notes that state law limits the extent of recovery of an MA overpayment to the amount of benefits incorrectly granted. Wis. Stats., § 49.497(1)(b).

An agency must use actual income received by a member in determining if an overpayment has occurred. MEH, §22.2.2.2. If there is a determination of an overpayment based on excess income, the agency may recover one of the following:

> •The lesser of fee-for-service services Medicaid paid or the amount the member would have paid toward a deductible (if eligible for a deductible).

> •The lesser of what the member paid or would have paid toward the deductible and the amount Medicaid has spent on HMO capitation payments.

Id.

If the reason for the overpayment is other than excess income, the overpayment that can be recovered is one of the following:

> •Amount paid for the medical services provided if the case is fee-for-service.
> •MCO 's capitation rate, less any contribution made by the member (for example, premium or cost share) if the case members are enrolled in a Medicaid MCO. The capitation rate is the monthly amount Medicaid pays to the member's MCO.

The agency is directed to use the simulation function in CARES to determine a member's eligibility, nursing home liability, premium, or cost share (if applicable) based on the corrected information (CARES Guide Chapter VIII, 1.4.1). Id.

The agency has the burden of proving not only the overpayment but it must also prove the amount of the overpayment is correct. The agency conceded at the hearing that, even though the Petitioner exceeded the program limits, he might have been eligible for some benefits after meeting a deductible or spend-down or with a monthly cost share. DHS is limited to recovering only the benefits to which the Petitioner was not entitled to receive.

1. Institutional MA Overpayment

The agency seeks to recover an overpayment of $151,207.53 for Institutional MA for the period of May 1, 2008 – April 30, 2009. The overpayment amount represents the net paid MA for the period. The Petitioner had been determined to be eligible for Institutional MA during that period with a monthly patient liability.

In addition to the MEH sections cited above with regard to determining the amount of an overpayment, the MEH gives the following guidance for overpayments for Institutional MA:

> 22.2.2.2.1 Institutional Overpayments
>
> The overpayment amount for an institutional case is the amount Medicaid paid.
> Note: Patient liability should not be subtracted from the claims paid by Medicaid when determining the overpayment amount.
>
> 22.2.2.2.1.1 Overpayment as a Result of Misstatement or Omission of Fact
>
> If a misstatement or omission of fact results in an increased nursing home liability or waivers cost share, the difference between the correct liability or cost share amount and the one the member originally paid is the overpayment amount.

The MEH requires the agency to conduct an analysis to determine whether the Petitioner would have been eligible for Institutional MA with an increased patient liability or with a deductible if he had properly reported his income. In this case, the agency seeks to recover an overpayment of net paid MA without first determining if the Petitioner would have been eligible for some benefits if he met a deductible or had an increased patient liability. Without the proper analysis of the Petitioner's eligibility for MA benefits, I cannot conclude that there was an overpayment. This decision does not prohibit the agency from re-

evaluating its overpayment claim and doing a proper analysis according to the regulations to determine if there was an overpayment and the amount of the overpayment.

2. Community Waivers Overpayment

The agency seeks to recover an overpayment of $896,985.27 for Community Waivers for the period of March 4, 2009 – September 30, 2012. This represents the net paid MA for the Petitioner for that period. The Petitioner had been determined to be eligible for Community Waivers during that period with no monthly cost share.

To be eligible for a Community Waivers program, an applicant must meet financial requirements for MA eligibility. In this case, the agency seeks to recover net paid MA benefits under the community waivers program. As with the Institutional MA overpayment, the agency must determine whether the individual would have been eligible for MA and determine the benefits he would have been eligible for in calculating the amount of any overpayment. Without evidence demonstrating that this analysis was conducted by the agency, I cannot conclude that there was an overpayment. This decision does not prohibit the agency from re-evaluating its overpayment claim and doing a proper analysis according to the regulations to determine if there was an overpayment and the amount of the overpayment.

3. MAPP Overpayment

The agency seeks to recover an overpayment of $323,921.77 for MAPP for the period of February 1, 2013 – April 30, 2014. This represents net paid MA for that period. The Petitioner had been determined eligible for MAPP with no monthly premium. The MEH addresses an overpayment of MAPP benefits as follows:

> 22.2.2.4 Premiums
> If a BadgerCare or MAPP case was still open for the time frame in question, but there was an increase in the premium, recover the difference between the premium paid and the amount owed for each month in question. To determine the difference, determine the premium owed and view the premium amount paid on CARES screen AGPT.
>
> 22.2.2.4.2 MAPP
> If the case was ineligible for MAPP, recover the amount of medical claims paid by the state. Deduct any amount the member paid in premiums (for each month in which an overpayment occurred) from the overpayment amount.

An individual is eligible for MAPP if income does not exceed 250% FPL. MEH, § 26.4. Individuals with incomes between 150% - 250% of FPL are eligible for MAPP with a monthly premium. MEH, § 26.5. When Petitioner first became eligible for MAPP on February 1, 2013, 250% of FPL was $2327.08/month. If Petitioner had properly reported his monthly income, he would not have been eligible for MAPP even with a monthly premium because his income exceeded 250% FPL. Effective February 1, 2014, 250% of FPL was $2,431.25. Petitioner's income continued to exceed the income limit for MAPP eligibility through the end of the overpayment period on April 30, 2014.

The agency produced the net paid MA claims report for MAPP benefits. The Petitioner did not pay any premiums. Therefore, I conclude the agency produced sufficient evidence to demonstrate that it has the authority to recover an overpayment of $323,921.77 for MAPP benefits paid to the Petitioner for the period of February 1, 2013 – April 30, 2014.

4. QMB Overpayment

The agency seeks to recover an overpayment of $7,268.50 for QMB for the periods of May 1, 2009 – June 30, 2009, February 1, 2010 – December, 2011, May 1, 2012 – December 31, 2012, and March 1, 2013 – April 30, 2014.

The MEH states the following with regard to an overpayment of QMB benefits:

> 22.2.2.4.2 Overpayments for Qualified Medicare Beneficiary Cases
>
> The overpayment amount for QMB cases is:
> 1.Medicare Part A premium if paid by the state (some are free, others are paid by the state).
> plus
> 2.Medicare Part B premium
> plus
> 3.Medicare deductibles
> plus
> 4.Medicare coinsurance
> Use the MMIS RC screen to determine if any Medicare deductibles and coinsurance payments were made by the state.

An individual is eligible for QMB benefits if income does not exceed 100% of FPL. MEH, § 32.2.3. When the Petitioner first applied for QMB benefits in May, 2009, 100% of FPL was $902.50/month. Subsequently, 100% of FPL was $907.50/month effective February 1, 2011, $930.83/month effective February 1, 2012, and $972.50 effective February 1, 2014. Petitioner's monthly income exceeded the income limit at the time of his application and in all months thereafter in the overpayment period. Therefore, he was not eligible for QMB benefits.

The agency produced reports (Exhibit #10) showing the premiums paid on behalf of the Petitioner as follows during the months of the overpayment:

May 1, 2009 – June 30, 2009	$ 192.80	(Claim #[redacted])
February, 2010 – December, 2010	$1215.50	(Claim #[redacted])
January, 2011 – December, 2011	$1384.80	(Claim #[redacted])
May, 2012 – December, 2012	$ 499.50	(Claim #[redacted])
March, 2013 – December, 2013	$ 944.10	(Claim #[redacted])
January, 2014 – April, 2014	$ 419.60	(Claim #[redacted])

Some of the overpayment amounts in the notices are not consistent with the premiums paid as reported in Exhibit #10. Specifically, the following overpayment amounts are inconsistent:

> Claim #[redacted], May 1, 2009 – June 30, 2009: The overpayment notice states the overpayment for this period is $1,267.30. The report in Exhibit #10 shows premiums paid in the amount of $192.80 for the period.
> Claim #[redacted], May 1, 2012 – December 31, 2012: The overpayment notices states the overpayment for this period is $1,198. The report in Exhibit #10 shows premiums paid in the amount of $499.50 for this period.
> Claim #[redacted], March, 2013 – December, 2013: The overpayment notice states the overpayment for this period is $1,258.80. The report in Exhibit #10 shows premiums paid in the amount of $944.10 for the period.

Claim #[redacted], January, 2014 – April, 2014: The overpayment notice states the overpayment for this period is $944.10. The report in Exhibit #10 shows premiums paid in the amount of $419.60 for the period.

These overpayment claims must be adjusted to reflect the premiums paid, according to the report in Exhibit #10.

CONCLUSIONS OF LAW

1. The agency demonstrated that the Petitioner failed to report countable income (the annuity income) when he applied and re-applied for various MA programs during the period of February, 2008 – April, 2014.

2. With regard to Institutional MA and Community Waivers, the agency did not meet its burden of demonstrating that there was an overpayment of benefits.

3. With regard to MAPP benefits, the agency demonstrated that it correctly calculated an overissuance in the amount of $323,921.77 for the period of February 1, 2013 – April 30, 2014.

4. With regard to QMB benefits, the agency demonstrated that it correctly calculated an overissuance for Claim Nos. [redacted] and [redacted]. The case is remanded to the agency to take all administrative steps necessary to revise the overpayment amounts for the following Claim Nos.:

Claim #	Revised Overpayment
[redacted]	$192.50
[redacted]	$499.50
[redacted]	$944.10
[redacted]	$419.60

THEREFORE, it is **ORDERED**

That this matter is remanded to the agency to do the following:

1. Take all administrative steps necessary to rescind Claim Nos. [redacted], [redacted], [redacted], [redacted] and [redacted] for Institutional MA and Community Waivers overpayments. These actions shall be completed within 10 days of the date of this decision.

2. Take all administrative steps necessary to revise Claim Nos. [redacted], [redacted], [redacted] and [redacted] for QMB overpayments in accordance with Conclusion #4 stated above. These actions shall be completed within 10 days of the date of this decision.

With regard to all other claims, the Petitioner's appeal is dismissed.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision.** Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,
Wisconsin, this 5th day of May, 2017

\s_____
Debra Bursinger
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
Suite 201
5005 University Avenue
Madison, WI 53705-5400

Telephone: (608) 266-3096
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on May 5, 2017.

Public Assistance Collection Unit
Public Assistance Collection Unit
Division of Health Care Access and Accountability
[redacted]